Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with the infection control guidelines set forth by the State Health Department and Centers for Disease Control and Prevention to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

I, ____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I have been made aware of the CDC and CT Department of Health guidelines that under the current pandemic, I am advised that non-emergent dental care should be delayed for patients 65 years of age or older or with underlying health conditions that put them at risk for infection with, or complications related to, COVID-19 (including those with lung disease, severe heart conditions, diabetes, liver or kidney disease, and immunocompromised individuals).

In order to reduce the risks of spreading COVID-19, we have asked you a number of "screening" questions below for the safety of our staff, other patient and most importantly yourself. Please be truthful and candid in your answers.

In the Last 14 days:	**IN-OFFICE**
Did you have fever (without fever reducing medication)	Yes ☐ No ☐
Are you having shortness of breath or other difficulties breathing?	Yes ☐ No ☐
Do you have dry cough?	Yes ☐ No ☐
Do you have any other flu-like symptoms, such as GI upset, headache, or muscle pain?	Yes ☐ No ☐
Have you experienced recent loss of taste or smell?	Yes ☐ No ☐
Do you have sore throat?	Yes ☐ No ☐
Do you have chills or repeated shaking with chills?	Yes ☐ No ☐
Have you been in contact with any confirmed COVID-19 positive patients?	Yes ☐ No ☐
Have you traveled outside Connecticut within last 14 days? If so, which state ____________________________	Yes ☐ No ☐

Appointment day temperature: ___________°F

Please be advised that any positive RESPONSES RECORDED on the day of the appointment will result in the appointment being rescheduled

Patient: ___________________________________ ______________________
Signature Date